FROM THE DIRECTOR

Col Patricia C. Lewis

As we come to a close on health services inspections for calendar year 2002, I thought it would be a good time to update you on inspection results. We accomplished 59 inspections to date with one inspection remaining, a total of 60 inspections. The overall results have improved slightly over CY 2001 results.

The AD inspections totaled 26 medical facilities (one remaining); 25 facilities received a mission ready rating and one unit received a mission ready with exception rating. The HSI score range was 72 to 96, with a mean score of 86. This is a slight improvement over last year's score range of 61 to 94 and mean score of 84. The JCAHO score range was 83 to 98, with a mean score of 93. We also stratified the active duty HSI results by peer group, but the difference in mean scores was not significant.

The ARC units inspected totaled 33 units, 15 Air Force Reserve units and 18 Air National Guard units. The overall HSI score range for all ARC units was 63 to 100, with a mean score of 86, which is a slight improvement over last year's mean score of 84. There were 18 Guard units inspected with a score range of 66 to 96 and a mean score of 84. For the Reserves, 15 units were inspected, with a score range of 63 to100 and a mean score of 88.

Overall, the inspections went well. Every medical unit spent considerable time preparing for this inspection, but as most of you have experienced, the key is in sustainment, not last minute preparation. If you're interested in the high findings for the year, take a minute to review the HSI Trend Analysis section of our web site.

AFI 36-2201, AIR FORCE TRAINING PROGRAM

CMSgt John Kettinger

Administration of the On-the-Job (OJT) Training Program and Supervisory Involvement--On-the-Job Training Program continue to be the two most problematic findings among the senior enlisted inspector's elements during Health Services Inspections (HSI). To assist all AF personnel, AFI 36-2201, Air Force Training Program, dated 30 Sep 02, has recently been released. All supervisors, trainers, unit training managers (UTM) and commanders must have an electronic version of this 6-volume instruction. This article will address some areas of AFI 36-2201. As with any new document, corrections are expected out just after the first of the year.

The primary reason for these discrepancies is that supervisors do not have an adequate understanding of the OJT program and are not adequately trained in documenting the 6-part folder. Secondly, personnel do not understand the importance of OJT to the USAF mission and individual success.

How important is OJT to our personnel? Have any of your troops lost an opportunity for promotion because they were in upgrade training too long? It hits you right in the checkbook, not to mention the loss of prestige and honor of a promotion. According to Volume 1, Training Management, Chapter 5, Training Evaluation, supervisors and trainers must evaluate formal course graduates to ensure training effectiveness (5.2.4.1.) This must be done during the first 90 days following assignment. At a minimum, you must evaluate the military bearing and technical ability. When you evaluate the trainee's technical ability, use the Specialty Training Standard (STS) contained in the CFETP. Evaluate the person's ability to perform tasks taught in the formal course at the specified training level.

Use the Customer Service Information Line listed in the CFETP to report training deficiencies identified in the initial evaluation. Document the deficiencies on AF Form 623a. Many 6-part folders lacked documentation, and without the written word, how do you prove it happened? All parties must sign the AF Form 623a after each entry.

Many of our folks do not understand core tasks. They do not know how to document the CFETP, whether it is initial training for the 5-skill level, transcribing to a new record, or documenting a Master Training Plan (MTP). Core tasks are areas that career field leaders deem necessary for upgrade training. They should be identified in the MTP and the individual's 6-part training folder as a prerequisite for advancement. Keep in ready contact with the MAJCOM functional manager as he/she may have a few ideas or may tell you to start putting together the documents for a waiver. Volume 5, Career Field Education and Training, Chapter 4 discusses waiver requests. Transcribing certified tasks to a CFETP are found in Volume 3, Chapter 8, 8.8, CFETP/AFJQS Documentation.

The most read volume of AFI 36-2201 is going to be Volume 3, On-the-Job Training Administration. Every UTM, supervisor, trainer and task certifier should have a paper

copy to highlight not just his or her areas of concern, but also all areas since the next higher level will inspect the level beneath.

The base training manager is a great source of information, and each UTM should take advantage of their expertise. The base training manager holds meetings quarterly and documents areas discussed in detail. The UTMs should pass this information on in their own meetings. In conjunction with these meetings, training sessions for 3S2X1's and additional duty UTMs must be conducted. This is a good time to ask questions or clarify job responsibilities. The base senior 3S2X1 is responsible for ensuring UTMs and additional duty training managers are trained and qualified by establishing a structured training program.

On-the-job training is a commander's program and commanders need to stay involved. The commander's primary assistant is the unit-training manager. If the UTM does not work directly for the commander, she should have direct access. Commanders must ensure UTM additional duties do not detract from primary duties (Volume 3, Chapter 4, 4.3.2). Not all medical units qualify for a 3S2X1 authorization. Units that do have these authorizations don't seem to have an advantage during HSIs, although units that don't have one may suffer in other areas. One problem is placing this responsibility as an additional duty to someone already heavily tasked. Another problem is that Senior Airmen and junior grade NCOs are placed in charge of the program. Many lack the knowledge of OJT, are afraid to speak up and have trouble getting support they need.

The UTM is to the medical unit what the base training manager is to the UTM. Medical unit personnel are looking to the UTM to provide guidance and assistance. UTMs need to take advantage of all the training they can get and place as many OJT helpers into the hands of supervisors and trainers to make their jobs easier. It is the UTM's responsibility to get the information out. The meetings must be adjusted to meet the needs of the workers. The UTM must analyze the trends from the information gathered by conducting informal and formal work center visits. The UTM should then provide feedback with recommendations how to fix the problems during the quarterly meetings. Good practices dictate that every unit member should have access to past and present meeting minutes either by E-mail or on a website. All helping documents, examples and other training devices should also be posted for easy access and review.

For all you UTMs out there, take this AFI and start orchestrating a training program that outlines the responsibilities of Chapter 6 into your quarterly meetings. You may find a greater compliance when your supervisors, trainers, task certifiers and trainees have a better understanding of what they are doing and what they are responsible for. The HSI senior enlisted inspectors will start inspecting units with the changes that have been implemented by AFI 36-2201 when the new HSI inspection guide takes effect in Jan 03.

AVIATION SOFT CONTACT LENS (SCL) PROGRAM—YOU May Have to be the "Bad Guy"

Major Scott Shepard and Major Judith Hughes

Poor fit or improper care and maintenance of contact lenses can result in unsafe flying conditions. Although guidance for this program is straightforward, many Air Reserve Component (ARC) units seem to inadequately manage aircrew that wear SCLs.

The HQ USAF/SG policy memorandum dated 15 May 96, *Aircrew Soft Contact Lens (SCL) Program*, outlines the guidance for this program and complements additional guidance found in AFI 48-123, *Medical Examinations and Standards*, Attachment 17. Common discrepancies found in ARC units include failure to identify all members in the SCL program, failure to ensure completion of annual follow-up examinations for members in the SCL program, and failure to suspend aircrew from the SCL program when they're found to be noncompliant with the annual examination requirement.

Some ARC unit SCL program managers are unsure of who is supposed to be enrolled in the SCL program. What if an Air National Guard pilot wears contacts while in his civilian job but states he does not wear them while flying military aircraft? AFI 48-123 has the answer—Flying Class I and II members electing to wear contacts on or off duty must adhere to the SCL program. Only Flying Class III members are not required to adhere to the policy if they elect to wear SCL off duty only.

Attachment 17 of AFI 48-123 makes it the responsibility of the aircrew member to self-identify and enroll in the SCL program. Aircrew can visit the local flight surgeon's office or self-identify when completing an AF Form 1042, *Medical Record for Flying or Special Operational Duty*, and checking the "I DO" block when asked if they wear soft contact lenses while performing flying or special operational duty. When they check "I DO," it then becomes the responsibility of flight medicine personnel to ensure these members are enrolled in the SCL program and, if they are not, to notify the flight surgeon so the aircrew member can be briefed and assessed for enrollment into the SCL program.

Follow-up eye examination requirements are outlined in the USAF Aircrew Soft Contact Lens Program Aircrew Instructions (Attachment 1 to the HQ USAF/SG policy memo). Tracking of these requirements is normally done by the optometry clinic with data reported to the flight surgeon, or often PES personnel do it in units without an optometrist assigned. Simple, locally developed, Microsoft Excel databases are typically used and are very effective when promptly updated and closely monitored.

USAF Aircrew SCL Program Instructions further state that failure to accomplish all follow-up examinations will result in suspension of the clearance to fly with SCL. Frequently, reluctance on the part of medical personnel to take this action allows aircrew to continue flying under potentially unsafe conditions. Do not hesitate to suspend a member's clearance, even if the flyer is a good friend. Accident investigation boards won't take that into consideration and will fault the flight surgeon for lack of adequate follow-up and failure to suspend the aviator's authorization to fly with SCLs.

Take seriously your responsibility for ensuring the safety of your unit's flying personnel. Manage the SCL program aggressively and take appropriate actions for members who are noncompliant. SCL program administration should be simple and take a minimum amount of time and effort.

DENTAL CUSTOMER SATISFACTION SURVEYS

Col Bill Basden

The Department of Defense (DoD) Dental Satisfaction Survey has been around for several years. As I visit bases, I often see variations in the use of the survey. I am not a survey expert, but do have some ideas for you to consider.

HOW DO YOU SHARE THE INFORMATION?

The information gained from this survey should be public knowledge. I know that not all of you think that way because I often see that this information is not available, not discussed in the dental executive committee minutes nor is it posted for patients or staff to see. For the majority of Air Force dental clinics, the information from this survey is positive news. I have no idea why we try to keep this information secret. My recommendation is to copy the results of the survey and post them in a conspicuous spot such as by the appointment window or the staffs' break room.

WHAT IS THE VITAL INFORMATION?

There is a plethora of information that can be derived from this survey. It certainly gives you a snapshot of how your clinic compares to other Air Force or DoD dental facilities. The demographics of who has completed the survey, what type of services they received and the level of patient satisfaction should be evaluated to identify opportunities for improvement.

CONCLUSION

I will be the first to say that the DoD Dental Satisfaction Survey was a pain in the neck when I was a dental squadron commander. Now that I am wearing another hat, it is easier for me to have a different perspective on the value of the survey. The survey is only one tool in our toolbox to evaluate the patient satisfaction at our clinics. I hope that this short article will inspire someone to reevaluate how you are using this tool!

WE NEED PERTINENT—NOT PRETTY

Maj Scott Brown

It's document review day for the HSI team, and the IG work center is awash with the smell of new vinyl. The local office supply store has sold all their white 3-ring binders, plastic document protectors and fancy document crates to the unit's HSI project officer. The unit has spent a couple thousand dollars and dozens, if not hundreds, of man-hours "packaging" documents in a way they believe will impress the inspectors—including unit mission, vision and goals repeated in each and every binder. Professionally bound packets in full color, likely costing $20 apiece (or more), are placed in the inspectors' hotel rooms, each containing documents we'll likely see duplicated the next day during documentation review.

Unfortunately, the long hours spent making everything pretty could be much better spent on pertinent preparation. Preparation should include review of guidance and the HSI Guide to ensure thorough understanding of program requirements and compliance with applicable directives. Preparation should include long, hard thought into the efficiency and effectiveness of unit management, section operations and the quality and completeness of program documentation. Preparation should include honest and comprehensive assessments using the unit self-inspection program, with quick follow-up actions for areas found deficient. Preparation should include purchase of medical supplies and equipment for the unit's true customers—the patients—not purchase of one-time-use office supplies to impress the HSI team.

HSI inspectors are primarily compliance inspectors. We're checking for compliance with AF, MAJCOM, wing and unit instructions and policy regarding unit leadership and medical programs and operations. Our assessments are based on criteria derived from these directives and summarized in the elements of the HSI Guide. Scores are based on the level of compliance with directives and the impact noncompliance has had on outcomes. "Pretty" isn't in the directives, isn't scorable and isn't something we look for or expect. Time is precious—especially in ARC units. Do make documentation orderly and easy to identify, but don't spend time and money preparing unnecessarily in ways that won't make a difference in the overall HSI score for your unit. Spend it providing better service for your customers.

HOSPITAL EMPLOYEE HEALTH PROGRAM (HEHP)

Maj Tim Bennett

Medical unit employee health program requirements are designed to protect the medical staff from infectious patients AND patients from infectious health care providers. Health care workers (HCW) with patient care responsibilities are categorized as having high-risk or exposure-prone duties.

Some units have had difficulty defining who is "exposure prone." CDC defines exposure-prone invasive procedures as procedures during which there is a recognized risk for percutaneous injury to the health care worker where, if an injury occurs, the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes. Most units use the HEHP defaults, which at a minimum includes most surgeons, dentists and dental technicians. High-risk workers are defined as those who have contact with patients or blood and are at ongoing risk for percutaneous injuries.

Human Immunodeficiency Virus (HIV) testing is an annual requirement for HCWs classified as high risk or exposure prone. New employees require a pre-employment HIV test if not accomplished in the past calendar year. This is a mandatory requirement for active duty.

All personnel assigned to, or working in, Air Force medical treatment facilities are required to be immunized against hepatitis B virus (HBV). Although prevaccination serologic screening for previous HBV infection is not recommended, health care workers who have contact with patients or blood and are at ongoing risk for percutaneous injuries (which includes both exposure-prone and high-risk personnel) should be tested for anti-HBV surface antigen(HBsAG), ideally 1-2 months after vaccination. Not all health care workers have had this serology done in this time frame. CDC indicates we should go beyond this period, stating a program of serologic testing for health care workers vaccinated prior to Dec 97 is not recommended. Based on this reference, Air Force medical inspectors expect units to do anti-HBsAG) testing on exposure-prone and high-risk HCWs who completed their HBV vaccination series more than 1-2 months ago (but not prior to Dec 97).

HCWs involved in exposure-prone procedures should know their HbsAG status. It is not sufficient for the worker to know only their HBV antibody status—several cases have been reported in which the HCW is both anti-HBs and HBsAG positive. Units recording only the antibody status should check the HCW's medical record to ensure an HBsAg test was done and record their status in the automated hospital employee health program. This serology should be done prior to the HCW treating patients. Don't wait until the worker completes their HBV immunization series to find out what their HBsAG status is—this potentially allows a HBV antigen positive individual to work on patients for 8 months or longer without appropriate precautions. In addition, all providers who are hepatitis B surface antigen positive must be tested for HBeAg and evaluated by the Credentials Committee for possible privilege restriction.

References:

1. 23 Oct 96 ASD Policy Memorandum, subject: *Hepatitis B Immunization Policy for Defense Medical and Dental Personnel.*

2. 26 Mar 96 HQ USAF/SG Policy Memorandum, subject: *Transmission of Hepatitis B During Surgery*

3. 15 Jan 97 HQ USAF/SG Policy Memorandum, subject: *Hepatitis B Immunization Policy for Air Force Medical and Dental Personnel*

4. CDC. *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients during Exposure-prone Invasive Procedures.* MMWR 1991; 40 (no. RR-8)

5. CDC. *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis.* MMWR 2001; 50(No. RR-11): [p. 16]

6. CDC. *Epidemiology and Prevention of Vaccine-Preventable Diseases.* 6th edition; 2nd printing, Jan 01: [p. 223]

7. 29 CFR 1910.1030, *Bloodborne Pathogens*

8. AFI 48-135, *Human Immunodeficiency Virus Program*

UNIFORM BUSINESS OFFICE AUDIT and COMPLIANCE PROGRAM

Lt Col Danita McAllister and Lt Col John Wiseman

AFI 41-120, Medical Resource Operations, paragraph 25.6 requires the medical treatment facilities (MTF) to establish and actively maintain an audit and compliance program to maintain good accounting practices. The Medical Service Account (MSA) system, Third Party Collections (TPC), and Third Party Liability (TPC)/Medical Affirmative Claims (MAC) involve exchange of funds between an outside source and the MTF. During the 1999 Uniform Business Office (UBO) Conference, each MTF was given a compliance binder to use in their facility to establish or improve their audit and compliance program. If your facility does not have a hard copy of the binder or you need to obtain updated information, the binder contents can be found on the TMA website. Just click on UBO in the pull-down window on the TMA home page or go directly to the UBO website using the following hyperlink: http://www.tricare.osd.mil/ebc/rm_home/ubo_home.cfm. Follow the trail to the Document Center and then to the Compliance page.

One of the items provided for download on this website is a document called "Auditing Tool (revised 2002)." This tool is simply a checklist template that can be tailored to your MTF's specific needs. The checklist includes sections for MSA, TPC and MAC and should be completed at least quarterly. If some of the checklist items are already being assessed in other processes, such as your data quality audits, they do not have to be repeated. To streamline internal processes, some MTFs have incorporated the requirements of both data quality and UBO functions into one all encompassing audit program. If you choose to keep these functions separate, please remember that data quality audits are required monthly while UBO audits are required quarterly.

A good place to maintain completed UBO audit checklists is in your compliance binder. If you discover any discrepancies as a result of your audit, be sure to include a plan for corrective action. You may want to include any identified discrepancies as part of your self-inspection program.